DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia Washington

To: Hospitals
Managed Care Plans
Regional Administrators
CSO Administrators

Memorandum No. 02-58 MAA
Issued: June 10, 2002

For more information, call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Subject: **Listing Client Spenddown and/or EMER on UB-92 Claim Form**

The purpose of this numbered memorandum is to clarify to hospitals the difference between Spenddown and EMER for the Medically Indigent Program and where each one MUST be placed on the UB-92 claim form in order for the hospital to be reimbursed properly.

What is Spenddown?

Spenddown is the process of assigning excess income for Medically Needy (MN) program and excess income and/or resources for Medically Indigent (MI) program to the client's cost of medical care. The amount is based upon the countable income the client receives during the base period that is above the Medically Needy Income Level (MNIL). The client must incur medical expenses equal to the excess income (Spenddown) before medical benefits can be authorized. [Refer to WAC 388-519-0120 Spenddown - Medically Indigent program.]

What is EMER?

EMER stands for Emergency Medical Expense Requirement. A client is required to meet a $2,000.00 EMER for the Medically Indigent (MI) program. The client is responsible for paying this regardless of whether there is any Spenddown. [Refer to WAC 388-438-0100 - Medically Indigent (MI) program.]

Note: MI clients will <u>always</u> have an EMER but may or may not have Spenddown. If the client has an EMER <u>and</u> a Spenddown requirement, **both** must be added together and listed on the claim form in form locator 57.

How does the hospital know the amount of the client's Spenddown and/or EMER?

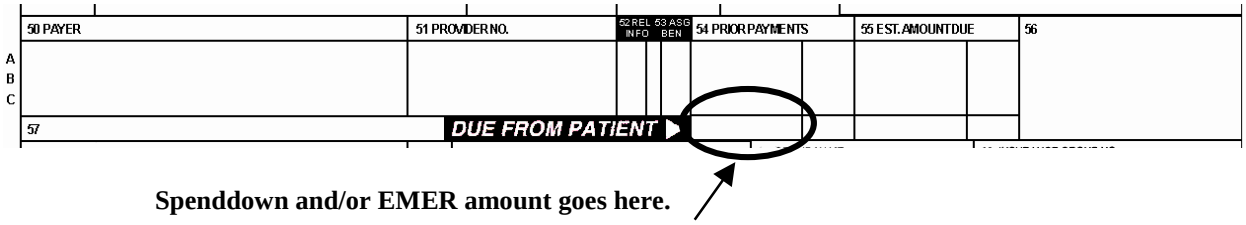
The amount of the client's Spenddown and/or EMER is listed at the bottom of the client's *Approval for MI EMER and/or Spenddown Met* Letter (otherwise known as an ACES award letter or medical award letter). This letter is issued by the client's local DSHS Community Services Office (see attached sample). The client's Spenddown and/or EMER is commonly referred to as the Patient's Liability or amount "Due from the Patient."

> ☞ **Note:** The local DSHS offices have been advised to send a copy of the client's *Approval for MI EMER/Spenddown Met* Letter to the hospitals when they approve the case.

Where does the client's Spenddown and/or EMER go on the UB-92 claim form?

When billing MAA, hospitals must place the Spenddown and/or EMER amount listed on the client's *Approval for MI/Spenddown Met* letter (see sample attached), when appropriate, in form locator 57 on the UB-92 claim form. Not adding the Spenddown and/or EMER amount on the UB-92 claim form may result in an overpayment to the hospital. If, during an audit review, an overpayment is found, MAA will recoup the overpayment.

Example: UB-92 Claim Form



How do I calculate the Estimated Amount Due?

Calculate the Estimated Amount Due (form locator 55A) as follows:

	Total Charges	(Form locator 47)
-	Noncovered Charges	(Form locator 48)
-	Prior Payments	(Form locator 54)
-	Due from Patient	(Form locator 57)
=	**Estimated Amount Due**	**(Form locator 55A)**

> ☞ **Note: Do not leave Form Locator 55A blank!** MAA will deny the entire claim if form locator 55A (Estimated Amount Due) is left blank.

Where is the client's Spenddown and/or EMER entered when billing electronically?

When billing MAA electronically, any Spenddown and/or EMER must be shown in:

RECORD TYPE:	20
RECORD NAME:	PATIENT DATA
FIELD NUMBER:	23
FIELD TITLE:	"PAYMENTS RECEIVED (PATIENT PAID)"

Attached: Sample *Approval for MI EMER/Spenddown Met* Letter

Replacement pages H.1 – H.8 for MAA's Inpatient Hospital Billing Instructions
(**These pages replace H.1 – H.12 in your current Billing Instructions.)**

Replacement pages I.1 – I.6 for MAA's Outpatient Hospital Billing Instructions
(These pages replace I.1 – I.12 in your current Billing Instructions.)

Olympia CSO
PO Box 1908
Olympia, WA 98507-1908

Sample Approval for MI EMER/Spenddown Met

01/18/02

Mr. John Doe
XXX South 1st Street
Anytown, WA 985XX

The following person will get emergency medical benefits (MI) beginning 02/01/02 through 04/01/02.

John Doe

You will get your first Medical Identification Card (coupon) in the mail within 3 days. After that, you will get it on the first day of each month. The card has your PIC (Patient Identification Code) on it. Please sign this card and keep it with you. You can only use this coupon to pay for the ambulance expenses and expenses at the hospital related to this emergency. This coupon will not cover your out of hospital expenses.

We looked at all of the DSHS medical programs. You can only get benefits from the program listed in this notice.

MI requires your family to have at least $2,000 of Emergency Medical Expenses (EMER). You have met this requirement as follows:

Anytown Hospital $14,000

According to our records this is what you need help paying:

Facility name:	Anytown Hospital		$14,000.00
Ambulance:			$450.00
Patient Name:	John Doe		
Dates of Service:		02/01/02	04/01/02
Total Bill Amount:			$14,450.00
Spenddown Amount:			$0
EMER:			$2,000.00
Total Amount You Owe:			$2,000.00

If your income is below the Federal Poverty Level for your family size, the hospital can not ask you to pay these bills.

Please let us know as soon as possible if your address changes.

We will send you an eligibility review form before your benefits stop. You must return the completed form to see if you can keep getting benefits.

If you disagree with any of our decisions, you may ask to have your case reviewed. You can also ask for a fair hearing. Your fair hearing rights are included in this letter.

You also show a bill for Dr. Smith for $200 for follow-up care in a clinic. We cannot help with this bill.

Please call me if you have any questions about this letter.

Case Worker's Name
Case Worker's Phone Number
Email

How to Complete the UB-92 Claim Form

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

☞ **Note:** Shaded fields are required fields only for UB-92 Medicare/Medicaid Crossover Claims." **Medicare/Medicaid Crossover Claims cannot be billed electronically.**

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a 20-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Indicate type of bill using 3 digits as follows:

Type of Facility (first digit)
1 = Hospital

Bill Classification (second digit)
1 = Inpatient

Frequency (third digit)
1 = Admit through discharge claim
2 = Interim - First Claim
3 = Interim - Continuing Claim
4 = Interim - Last Claim
5 = Late Charge(s) Only Claim

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's Medical Identification card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birthdate (MMDDYY).

15. **Patient's Sex** - Enter the client's sex (M or F).

17. **Admission Date** - Enter the date of admission (MMDDYY).

18. **Admission Hour** - The hour which the patient was admitted for inpatient care. Use the appropriate two-digit code listed in the following list:

Code	Time: A.M.	Code	Time: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

19. **Type of Admission** - Enter type of admission.

1 = Emergent
2 = Urgent
3 = Elective
4 = Newborn

20. **Source of Admission** - Enter source of admission.

1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from a hospital
5 = Transfer from a skilled nursing facility
6 = Transfer from another health care facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available

21. **Discharge Hour** - The hour during which the patient was discharged from care. (Use **Admission Hour** list.)

22. **Patient Status** - Enter one of the following codes to represent the disposition of the client at discharge:

01 = Discharge to home or self care (routine discharge)
02 = Discharged/transferred to another short-term general hospital for inpatient care
03 = Discharged/transferred to nursing facility (SNF)
04 = Discharged/transferred to an intermediate care facility (ICF)
05 = Discharged/transferred to another type of institution for inpatient care
06 = Discharged/transferred to home under care of home health service organization
07 = Left against medical advice or discontinued care
20 = Expired
30 = Still patient

24.-30. **Condition Codes** – Enter one of the following, as appropriate:

LT = Long Term Acute Care
R1 = Level A
R2 = Level B
X1 = Trauma Condition Code

32-35. Occurrence Codes and Dates - Beginning in form locator 32, enter the appropriate occurrence code.

Following are some common examples of occurrence codes. Please refer to your UB-92 manual for a complete listing:

01 = Auto Accident
02 = Auto Accident/No Fault Insurance Involved
03 = Accident/Tort Liability
04 = Accident/Employment Related
05 = Other Accident
J0 = Baby on mom's PIC

38. Responsible Party Name and Address – Enter the name and address of the party responsible for the bill.

39-41. Value Codes and Amounts – Enter one of the following, as appropriate:

45 = Accident Hour (use the chart listed next to form locator 18 for admission hours)

80 = Newborn's birthweight in grams

39-41. Value Codes and Amounts

Medicare Crossover claims only

39A: **Deductible**: Enter the code *A1*, and the deductible as reported on your EOMB.

39D: **ENC Rate**: Enter Med's ENC rate as reported on the EOMB.

40A: **Coinsurance**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

40D: **Encounter Units**: Enter the encounter units Medicare paid, as reported on EOMB.

41A: **Medicare Payment**: Enter the payment by Medicare as reported on your EOMB.

41D: **Medicare's Process Date**: Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

42. Revenue Code - Enter the appropriate revenue code(s) from the listing in this manual.

Enter *"001"* in the last detail line 23 for total charges.

43. Description - Revenue Code(s) - Enter a narrative description of the related revenue code(s) included on this bill. Abbreviations may be used.

Enter *"Total Charges"* on the last detail line 23.

44. HCPCS/Rates - Enter the accommodation rate for inpatient bills.

46. Units of Service - Enter the quantity of services listed by revenue codes.

47. **Total Charges** - Enter charges pertaining to the related revenue code(s). **Total this column as the last detail on line 23.**

48. **Noncovered** – Enter any noncovered charges pertaining to detail revenue or procedure codes. (MAA will *categorically deny* these services.) **Total this column as the last detail on line 23.**

50. **Payer Identification: A/B/C** - Enter all health insurance benefits available.

50A: Enter ***Medicaid***.
50B: Enter the name of additional insurance (e.g., Medicare, Aetna, etc.), if applicable.
50C: Enter the name of additional insurance, if applicable.

51A. **Provider No. –** Enter the seven-digit MAA provider number beginning with a "3" that appears on your Remittance and Status Report.

Medicare Crossover claims only

51B: Enter your Medicare provider number.

54. **Prior Payments: A/B/C** - Enter the amount due or received from all insurances. **Do not include Spenddown or EMER here. See form locator 57.**

54A: Enter any prior payments from payor listed in form locator 50A.
54B: Enter any prior payments from payor listed in form locator 50B.
54C: Enter any prior payments from payor listed in form locator 50C.

55. **Estimated Amount Due: A/B/C** –

55A: Enter the estimated amount due from MAA minus any amounts listed in form locators 48, 54, and 57.
55B: Not required to be filled in.
55C: Not required to be filled in.

57. **Due from Patient (Patient Liability)** Enter the total patient liability amount which includes Spenddown and/or EMER.

☞ Refer to the bottom of the client's *Approval for MI EMER/Spenddown Met* Letter issued by the local DSHS Community Service Office for the Spenddown and/or EMER amount.

58. **Insured's Name: A/B/C** – Enter the name of the individual in whose name the insurance is carried.

60. **Cert-SSN-HIC-ID NO.** - Enter the MAA Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client. This information is obtained from the client's current monthly Medical ID card and consists of:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters/characters of the last name. (If fewer than five letters in the last name, use spaces before adding the tiebreaker. Or in the case of a hypenated name, use hypens.)
d. An alpha or numeric character (tiebreaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization** - Enter the assigned authorization number (be sure to enter all nine digits).

64. **Employment Status Code** – Enter the code used to define the employment status of the individual identified in Form Locator 58.

1 =Employed full time
2 =Employed part time
3 =Not employed
4 =Self-employed
5 =Retired
6 =Active Military
9 =Unknown

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

68-75. **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

76. **Admitting Diagnosis** – Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

80. **Principal Procedure Code** - The code that identifies the principal procedure performed during the period covered by this bill.

81 A-E **Other Procedure Codes** - The codes identifying all significant procedure(s) other than the principal procedure.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - Enter the referring provider number, or if unknown, enter the name of the provider who referred the client to services. If the client is under PCCM, you must use the referring PCCM provider number.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form.

APPROVED OMB NO. 0938-0279

ST. ANYWHERE
1234 MAIN STREET
ANYTOWN, WA 98XXX

3 PATIENT CONTROL NO. 123456 | 4 TYPE OF BILL 111

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM 070102 THROUGH 070802 | 7 COV'D. | 8 N-C'D. | 9 C-I'D. | 10 L.O.S. | 11

12 PATIENT NAME: MARY JANE SMITH

13 PATIENT ADDRESS: 1111 MARKET ST
ANYTOWN, WA 98XXX

14 BIRTHDATE | 15 | 16 | 17 DATE | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO.

ADMISSION 19 1 7 19 01

CONDITION CODES 24 X1 25 26 27 28 29 30

31 CODE OCCURRENCE DATE | 34 CODE OCCURRENCE DATE | 35 CODE OCCURRENCE DATE | 36 CODE OCCURRENCE SPAN FROM THROUGH | 37 A B C

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT
a
b
c
d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
120	ROOM AND BOARD SEMI-PRIV	500.00		7	3500 00		
250	PHARMACY			235	1500 00		
270	MEDICAL SUPPLIES			65	1500 00	100 00	
300	LABORATORY			50	1500 00		
320	RADIOLOGY			50	1500 00		
450	EMERGENCY ROOM			10	1600 00		
001	TOTAL CHARGES				11,100 00	100 00	

SAMPLE

50 PAYER | PROVIDER NO. | 52 REL. INFO | 53 ASG. BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

50 PAYER	PROVIDER NO.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
MEDICAID	3XXXXXX	0 00	8300 00
BLUE CROSS		700 00	
	DUE FROM PATIENT	2000 00	

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
MARY JANE SMITH		MJ999999SMITHA	MEDICAID	
MARY JANE SMITH		999-99-9999	UNIFORM	

63 TREATMENT AUTHORIZATION CODES: 9999999 | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.: 813.0 | 68 CODE | 69 CODE | OTHER DIAG. CODES 70 CODE | 71 CODE | 72 CODE | 73 CODE | 74 CODE | 75 CODE: 873. 842.0

76 ADM. DIAG. CD.: 813.0 | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE: 070102 B | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE | OTHER PROCEDURE CODE DATE

82 ATTENDING PHYS. ID: DR. JIM JONES

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X | 86 DATE

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 | OCR / Original

This is a blank page.

How to Complete the UB-92 Claim Form

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

☞ **Note:** Shaded fields are required fields only for UB-92 Medicare/Medicaid Crossover Claims. **Medicare/Medicaid Crossover Claims cannot be billed electronically.**

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a 20-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Indicate type of bill using 3 digits as follows:

Type of Facility (first digit)
1 = Hospital

Bill Classification (second digit)
3 = Outpatient

Frequency (third digit)
1 = Admit through discharge claim
2 = Interim - First Claim
3 = Interim - Continuing Claim
4 = Interim - Last Claim
5 = Late Charge(s) Only Claim

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's Medical Identification card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birthdate (MMDDYY).

15. **Patient's Sex** - Enter the client's sex.

17. **Admission Date** - Enter the date of admission (MMDDYY).

18. **Admission Hour** - The hour during which the patient was admitted for outpatient care. Use the appropriate two-digit code listed in the next column.

Code	Time: A.M.	Code	Time: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

19. **Type of Admission** - Enter type of admission.

1 = Emergent
2 = Urgent
3 = Elective
4 = Newborn

20. **Source of Admission** - Enter source of admission.

1 = Physician Referral
2 = Clinic Referral
3 = HMO Referral
4 = Transfer from a hospital
5 = Transfer from a nursing facility
6 = Transfer from another health care facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information Not Available

21. **Discharge Hour** - The hour during which the patient was discharged from outpatient care. (Use **Admission Hour** list.)

22. **Patient Status** - Enter one of the following codes to represent the disposition of the client at discharge:

01 = Discharge to home or self care (routine discharge)
02 = Transferred to another short-term general hospital
03 = Discharged/transferred to nursing facility (SNF)
04 = Discharged/transferred to nursing facility (ICF)
05 = Transferred to an exempt unit or hospital
06 = Discharged/transferred to home under the care of an organized home health service organization
07 = Left against medical advice
20 = Expired
30 = Still patient

24.-30. **Condition Codes** – Enter one of the following, as appropriate:

LT = Long Term Acute Care
R1 = Level A
R2 = Level B
X1 = Trauma Condition Code

32-35. Occurrence Codes and Dates - Beginning in form locator 32, enter one or more of the following codes, if applicable.

01 =	Auto Accident
02 =	Auto Accident/No Fault Insurance Involved
03 =	Accident/Tort Liability
04 =	Accident/Employment Related
05 =	Other Accident
J0 =	Baby on mom's PIC

38. Responsible Party Name and Address – Enter the name and address of the party responsible for the bill.

39-41. Value Codes and Amounts – Enter one of the following, as appropriate:

45 = Accident Hour (use the chart listed next to form locator 18 for admission hours)

39-41. Value Codes and Amounts

Medicare Crossover claims only

39A: **Deductible**: Enter the code *A1*, and the deductible as reported on your EOMB.

39D: **ENC Rate**: Enter Med's ENC rate as reported on the EOMB.

40A: **Coinsurance**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

40D: **Encounter Units**: Enter the encounter units Medicare paid, as reported on EOMB.

41A: **Medicare Payment**: Enter the payment by Medicare as reported on your EOMB.

41D: **Medicare's Process Date**: Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

42. Revenue Code - Enter the appropriate revenue code(s) from the listing in this manual.

Enter ***"001"*** on the last detail line 23 for total charges.

43. Description - Revenue Code(s) - Enter a narrative description of the related revenue code(s) included on this bill. Abbreviations may be used.

Enter *"Total Charges"* on the last detail line 23.

44. HCPCS/Rates - Enter the CPT or HCPCS code with the appropriate modifier.

46. Units of Service - Enter the quantity of services listed by revenue or procedure code(s).

47. Total Charges - Enter charges pertaining to the related revenue code(s) or procedure code(s). **Total this column as the last detail on line 23.**

48. Noncovered - Any noncovered charges pertaining to detail revenue or procedure codes should be entered here. (MAA will *categorically deny* these services.) **Total this column as the last detail on line 23.**

50. **Payer Identification: A/B/C** - Enter all health insurance benefits available.

50A: Enter ***Medicaid***.
50B: Enter the name of additional insurance (e.g., Medicare, Aetna, etc.), if applicable.
50C: Enter the name of additional insurance, if applicable.

51A. **Provider No. –** Enter the seven-digit Medical provider number beginning with a "3" that appears on your Remittance and Status Report.

Medicare Crossover claims only

51B: Enter your Medicare provider number.

54. **Prior Payments: A/B/C** - Enter the amount due or received from all insurances. **Do not include Spenddown or EMER here. See form locator 57.**

54A: Enter any prior payments from payor listed in form locator 50A.
54B: Enter any prior payments from payor listed in form locator 50B.
54C: Enter any prior payments from payor listed in form locator 50C.

55. **Estimated Amount Due: A/B/C** –

55A: Enter the estimated amount due from MAA minus any amounts listed in form locators 48, 54, and 57.
55B: Not required to be filled in.
55C: Not required to be filled in.

57. **Due from Patient (Patient Liability)** Enter the total patient liability amount which includes Spenddown and/or EMER.

☞ Refer to the bottom of the client's *Approval for MI EMER/Spenddown Met* Letter issued by the local DSHS Community Service Office for the Spenddown and/or EMER amount.

58. **Insured's Name: A/B/C** – Enter the name of the individual in whose name the other insurance is carried.

60. **Cert-SSN-HIC-ID NO.** - Enter the MAA alphanumeric Patient Identification Code (PIC) assigned to each MAA client. This information is obtained from the client's current monthly Medical ID card and consists of:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d. An alpha or numeric character (tiebreaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization** - Enter the assigned authorization number (be sure to enter all nine digits).

64. **Employment Status Code** – Enter the code used to define the employment status of the individual identified in Form Locator 58.

1 = Employed full time
2 = Employed part time
3 = Not employed
4 = Self-employed
5 = Retired
6 = Active Military
9 = Unknown

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

68-75. **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

76. **Admitting Diagnosis** – Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

80. **Principal Procedure Code** - The code that identifies the principal procedure performed during the period covered by this bill.

81 A-E **Other Procedure Codes** - The codes identifying all significant procedure(s) other than the principal procedure.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D.** - Enter the referring provider number, or if unknown, enter the name of the provider who referred the client to services. If the client is under PCCM, you must use the referring PCCM provider number.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form.

ST. ANYWHERE
1233 MAIN STREET
ANYTOWN, WA 98XXX

2

3 PATIENT CONTROL NO. 123456

4 TYPE OF BILL 131

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 070102 THROUGH 070202

7 COV D. | 8 N-C D. | 9 C I D. | 10 L-R D.

12 PATIENT NAME: GEORGE SMITH

13 PATIENT ADDRESS: 1111 MORKET ST. ANYTOWN, WA 98XXX

14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.
MMDDYYYY	M			23			08		

CONDITION CODES 24 25 26 27 28 29 30

	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a												A
b												B
												C

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	450	EMERGENCY ROOM		070102	1	1,600 00		
2	350	CT SCAN	70470	070102	1	400 00		
3	300	CBC AUTO DIFFERENTIAL	85025	070102	1	60 00		
4	300	COMP METABOLIC PANEL	80053	070202	1	45 00		
5	250	PHARMACY		070102	30	100 00		
6	270	MEDICAL/SURG SUPPLIES		070102	40	150 00		
7								
8								
9								

SAMPLE

001 TOTAL CHARGES 2,355 00

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	MEDICAID	3XXXXXX				1,855 00	
B							
C							

57

DUE FROM PATIENT 500 00

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	GEORGE SMITH		G-999999SMITHB		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC
A		
B		
C		

66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD	77 E-CODE	78
873.0											

OTHER DIAG. CODES

PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
86.59	070102	A			

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
C		D		E	

82 ATTENDING PHYS. ID: 9999999 DR. JOHN JOHNSON

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X

86 DATE

UB-92 HCFA-1450

OCR / Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MA PART HEREOF.

State of Washington
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
PO Box 9245, Olympia, WA 98507-9245

Change Service Requested